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The Gutting of the Peer Review Protection Act: How *Reginelli v. Boggs* Weakened the Protection of Medical Peer Review in Pennsylvania and Why the General Assembly Must Act to Restore That Protection

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*Samuel C. Nolan**

I. INTRODUCTION

The medical peer review process is vital to many of the goals of the United States medical community. This process, through which physicians review the clinical performance of their colleagues, is designed to promote quality of care, improve patient safety, and lower overall health care costs by preventing medical malpractice and accompanying lawsuits.[1] Understanding the importance of the peer review process and the reluctance of physicians to participate in the

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1. *See generally* Kenneth R. Kohlberg, *The Medical Peer Review Privilege: A Linchpin for Patient Safety Measures*, 86 MASS. L. REV. 157, 157 (2002).

process without legal protections, legislatures in all fifty states and the District of Columbia have passed laws to keep the peer review process confidential.[2] These laws protect physicians from liability for their good faith actions as peer reviewers, impose confidentiality requirements on the process, and provide an evidentiary privilege which protects peer-review-related records and proceedings from discovery in lawsuits.[3]

Pennsylvania's peer review statute, the Peer Review Protection Act (PRPA),[4] was recently scrutinized by the Pennsylvania Supreme Court in *Reginelli v. Boggs*.[5] In *Reginelli*, a 4-3 majority narrowly interpreted the evidentiary privilege of the PRPA,[6] holding that the privilege cannot be extended to documents controlled by a non-licensed entity, such as a medical practice group.[7] The court also held that the privilege cannot apply to documents created by one member of the medical staff who reviews the cases of another member of the medical staff, outside of a pre-established committee.[8] As the three-justice dissent pointed out, this holding is at odds with the intent of the Pennsylvania General Assembly in drafting the PRPA.[9] This Note will further argue that this holding, which limits the protections of the PRPA to specific individuals and organizations in a conceptualization of a peer review process, unsupported by modern hospitals and health care systems, undermines the very goals of ensuring confidentiality for peer review activities, and jeopardizes the objectives of an effective peer review process. Finally, this Note will address why the Pennsylvania General Assembly must now act quickly to restore the broad protection of the PRPA, given the Act's ultimate objective of keeping patients safe.

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2. George E. Newton II, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 ALA. L. REV. 723, 723 (2001) ("[E]very state legislature and Congress provide protection to the participants and work product of peer review committees in the form of statutory privilege, confidentiality requirements, and limited immunity from legal liability or some combination of these.").

3. *Id.* at 723-24.

4. PRPA, 63 PA. STAT. AND CONS. STAT. ANN. §§ 425.1-425.4 (West 2017).

5. 181 A.3d 293 (Pa. 2018).

6. *Id.*; 63 PA. STAT. AND CONS. STAT. § 425.4.

7. *Reginelli*, 181 A.3d at 308. A medical practice group, or "physician group," is a collection of physicians who share resources and contract as a single entity. *See* Philip Masters, *Types of Medical Practices*, AM. C. PHYSICIANS, https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/guidance/types-of-medical-practices (last visited Mar. 30, 2019). These groups vary in size and may be composed of physicians from a single specialty or multiple specialties. *Id.* Physician groups often contract with hospitals to provide medical staffing. *Id.*

8. *Reginelli*, 181 A.3d at 304.

9. *Id.* at 320 (Wecht, J., dissenting).

II. PEER REVIEW GENERALLY

A. Brief History and Purpose

Medical peer review is the process by which physicians and other health care providers evaluate the clinical performance of their colleagues.[10] The peer review process is designed to ensure that providers are treating patients to an adequate standard of care, which in turn improves patient safety and reduces the risk for medical malpractice suits.[11] Peer review is the primary "method of evaluating the quality of physician services at . . . hospital[s]" and "is performed in a variety of settings, such as part of the quality assurance program of a hospital or other health care institution, a medical society or a third-party payer of health care expenses."[12] One of the "fundamental rationale[s] behind the peer review process is efficiency—practicing physicians are in the best position to determine the competence of other practicing physicians."[13]

In a hospital setting, physicians are reappointed to the medical staff every two years.[14] That reappointment process includes a peer review of the physician's core competencies.[15] Hospitals may also conduct a focused peer review of a physician if a specific medical incident or quality concern is raised.[16] Hospitals also engage in ongoing peer review as a way to continually improve patient care by randomly selecting cases for review, or evaluating threshold indicators, hoping to root out underlying issues or substandard care.[17]

The underpinnings of peer review are built into the Medicare Conditions of Participation which require that hospitals "develop, implement, and maintain an effective, ongoing, hospital-wide, data-

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10. Kohlberg, *supra* note 1, at 157.

11. *See id.*; *see also* Laurie K. Miller, *Defending the Peer Review Privilege: Guidance for Health Care Providers and Counsel After Wheeling Hospital*, 120 W. VA. L. REV. ONLINE 34, 35-37 (2017) (discussing the importance of peer review as a tool for reviewing and improving physician performance and patient care).

12. Miller, *supra* note 11, at 34 (quoting Susan O. Scheutzow, *State Medical Peer Review: High Cost but No Benefit–Is It Time for a Change?*, 25 AM. J.L. & MED. 7, 12-13 (1999)).

13. Newton, *supra* note 2, at 723; *see also* Bredice v. Doctors Hosp., Inc., 50 F.R.D. 249, 250 (D.D.C. 1970) ("The value of these discussions and reviews in the education of the doctors who participate, and the medical students who sit in, is undeniable.").

14. Lisa M. Nijm, *Pitfalls of Peer Review: The Limited Protections of State and Federal Peer Review Law for Physicians*, 24 J. LEGAL MED. 541, 544 (2003).

15. *Id.*

16. *Id.*

17. Dinesh Vyas & Ahmed E. Hozain, *Clinical Peer Review in the United States: History, Legal Development and Subsequent Abuse*, 20 WORLD J. GASTROENTEROLOGY 6357, 6358 (2014).

driven quality assessment and performance improvement program."[18] Furthermore, the Joint Commission[19]—the nation's foremost hospital accrediting body—"requires hospitals to conduct peer review to retain accreditation."[20] It is, therefore, a practical necessity for hospital medical staff to conduct peer review.[21] Additionally, the federal Health Care Quality Improvement Act,[22] which was enacted to give medical staff the tools to identify incompetent physicians, relies primarily on the medical peer review process as a means of detecting and reporting such physicians to the National Practitioner Data Bank.[23]

Apart from being required for accreditation, peer review is conducted primarily in the interest of the public good. As the Pennsylvania Superior Court has stated, peer review statutes like the PRPA are designed "to encourage increased peer review activity which will result, it is hoped, in improved health care."[24] To achieve that end, however, state legislatures like Pennsylvania's have

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18. 42 C.F.R. § 482.21 (2019).

19. The Joint Commission is an "independent, not-for-profit organization" that evaluates, "accredits[,] and certifies nearly 21,000 health care organizations and programs in the United States." *About the Joint Commission*, JOINT COMMISSION, https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx (last visited Feb. 2, 2019). "Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards." *Id.* Joint Commission accreditation satisfies the accreditation standards of the Centers for Medicare and Medicaid Services. *CMS and JCAHO Make It Easier for Consumers to Assess Hospital Quality*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 15, 2004), https://www.cms.gov/newsroom/press-releases/cms-and-jcaho-make-it-easier-consumers-assess-hospital-quality (announcing that the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission (formerly the Joint Commission on the Accreditation of Healthcare Organizations) had adopted unified performance metrics for hospitals).

20. Vyas & Hozain, *supra* note 17, at 6357.

21. About ninety-five percent of physicians participate as providers under Medicare and are therefore governed by CMS's accreditation requirements. *See* HARRIET KOMISAR, AARP PUB. POL'Y INST., MEDICARE'S FINANCIAL PROTECTIONS FOR CONSUMERS: LIMITS ON BALANCE BILLING AND PRIVATE CONTRACTING BY PHYSICIANS 1 (2017), https://www.aarp.org/content/dam/aarp/ppi/2017-01/medicare-limits-on-balance-billing-and-private-contracting-ppi.pdf.

22. 42 U.S.C. §§ 11101-11152 (2012).

23. Teresa L. Salamon, Note, *When Revoking Privilege Leads to Invoking Privilege: Whether There Is a Need to Recognize a Clearly Defined Medical Peer Review Privilege in* Virmani v. Novant Health, Inc., 47 VILL. L. REV. 643, 644-45 (2002). The National Practitioner Data Bank is a repository containing information on physicians who have engaged in malpractice or who have been subject to an adverse action by a hospital or other health care entity. *About Us*, NAT'L PRAC. DATA BANK, https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp (last visited Apr. 20, 2019). The Data Bank helps hospitals identify and prevent physicians from moving from state-to-state or hospital-to-hospital without their "previous damaging performance" being discovered. *Id.*

24. Sanderson v. Frank S. Bryan, M.D., Ltd., 522 A.2d 1138, 1139 (Pa. Super. Ct. 1987); *see also* Robinson v. Magovern, 83 F.R.D. 79, 87 (W.D. Pa. 1979) (stating that the PRPA, specifically, was designed "to encourage peer evaluation of the health care . . . so as to: (1) improve the quality of the care rendered; (2) reduce morbidity and mortality; and (3) keep within reasonable bounds the cost of health care.").

found they must remove the barriers keeping physicians from freely participating in the peer review process.[25] Physicians have historically "been reluctant to serve on peer review committees"[26] for fear of being involved in legal actions for defamation, discrimination, and antitrust.[27] Additionally, physicians may be reluctant to participate in the peer review of their colleagues because they are concerned about professional and personal retaliation: from losing patient referrals, which can affect a physician's financial earnings, to losing friends and jeopardizing other personal relationships.[28] Given these possible consequences, even when physicians participate in the peer review process, it is difficult to ensure that peer review is being done thoroughly and effectively.

Recognizing this reluctance and the value of the peer review process, state legislatures across the country have passed laws to protect the integrity of the process.[29] As mentioned, these laws generally provide immunity for physicians who participate in reviewing the care provided by their peers and create an evidentiary privilege protecting records and proceedings from discovery in a lawsuit against the hospital or other peer reviewing body or individual.[30] Without this evidentiary protection, even if the hospital, medical staff, physician groups, and individual physicians are diligent in maintaining confidentiality, physicians may be less likely to engage in a meaningful peer review process, knowing that their peer review records may be uncovered through litigation. Hence the need for a broad, predictable peer review protection. Without such protection, the trust upon which the modern peer review process is built may evaporate quickly, discouraging physicians from conducting the kind of thorough, candid peer review required to achieve the important objectives of the process.

B. Peer Review in the Modern Hospital

A hospital medical staff is the collection of practitioners—primarily physicians and advanced practice professionals, such as ad-

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25. Newton, *supra* note 2, at 723.

26. Nijm, *supra* note 14, at 541.

27. Jeanne Darricades, Comment, *Medical Peer Review: How Is It Protected by the Health Care Quality Improvement Act of 1986?*, 18 J. CONTEMP. L. 263, 271 (1992).

28. *See id.*

29. *See, e.g.*, 63 PA. STAT. AND CONS. STAT. ANN. §§ 425.1-425.4 (West 2017); DEL. CODE ANN. tit. 24 § 1739 (West, Westlaw through 81 Laws 2018); WYO. STAT. ANN. § 35-2-910 (West, Westlaw through 2018 Budget Sess.).

30. *See generally* DEL. CODE ANN. tit. 24 § 1739; WYO. STAT. ANN. § 35-2-910.

vanced practice nurses and physician assistants—who are credentialed to treat patients in a given hospital.[31] Unlike most businesses, hospitals did not historically employ the physicians who work and operate within their facilities.[32] Instead, a significant portion of a hospital's medical staff was comprised of private practice physicians.[33] Today, the medical staff more often consists of physicians from hospital-affiliated medical groups and other outside employers, today, "[p]eer review occurs in numerous settings, from the hospital to private practice. . . . [and] may occur in a medical practice group or in a managed care organization."[34]

Despite these changes, the hospital still often exists at the center of the peer review process.[35] In many hospitals, medical staff leadership selects members of the medical staff to serve on a peer review committee.[36] Some state laws prescribe specific criteria that a peer review committee must meet,[37] while others leave those decisions to the medical staff.[38] In general, however, these committees are formed "to evaluate and improve the quality of health care rendered by providers of health services."[39] The members of such a committee then analyze and critique the services rendered by physicians at the hospital, most often by reviewing the medical charts generated for each patient interaction.[40] While most peer review is done internally, peer review committees occasionally send cases for external review if they lack the resources to accommodate a thorough review.[41] This may occur if, for example, there is only one physician

31. Letter from Dir. of the Survey and Certification Grp., Ctr. for Medicaid and State Operations, to the State Survey Agency Dirs., Ctr. for Medicaid and State Operations (Nov. 12, 2004), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCletter05-04.pdf (defining the composition and role of the medical staff).

32. *See Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2016*, PHYSICIANS ADVOC. INST. (Sept. 2016), http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Physician-Employment-Study.pdf. The Physicians Advocacy Institute is a national, not-for-profit advocacy group. *Id.* To produce this study, the Physicians Advocacy Institute collaborated with Avalere Health, a health care consultant group, to examine and report on "national and regional changes in physician employment trends." *Id.*

33. *See id.*

34. Nijm, *supra* note 14, at 556 n.1.

35. *See* Brendan A. Sorg, Comment, *Is Meaningful Peer Review Headed Back to Florida?*, 46 AKRON L. REV. 799, 802-03 (2013).

36. *Id.*

37. *E.g.*, IND. CODE ANN. § 34-6-2-99 (West, Westlaw through 2018 Second Reg. Sess.).

38. *E.g.*, ARK. CODE ANN. § 20-9-501 (West, Westlaw through 2018 Fiscal Sess.).

39. *Id.* § 20-9-501(1) (establishing the goals of a peer review committee under Arkansas law).

40. Vyas & Hozain, *supra* note 17, at 6358 ("Today, the majority of peer review conducted in the United States occurs exclusively through retrospective chart review . . . .").

41. *See, e.g.*, Patrick v. Floyd Med. Ctr., 565 S.E.2d 491, 497 (Ga. Ct. App. 2002) (discussing external peer review).

in the hospital belonging to a given specialty, or a potential conflict of interest arises.[42]

III. PENNSYLVANIA'S PEER REVIEW PROTECTION ACT (PRPA)

Passed in 1974,[43] the PRPA provides two key protections for physicians and health care organizations regarding the peer review process in Pennsylvania: an *immunity* provision, protecting eligible individuals and organizations from legal liability,[44] and an *evidentiary* privilege, protecting the confidentiality of "proceedings and records of a review committee," by limiting their discoverability in legal proceedings.[45] The PRPA was described by the General Assembly as "[a]n Act providing for the increased use of peer review groups by giving protection to individuals and data who report to any review group."[46] Beyond that description, as the Pennsylvania Superior Court has lamented, "[u]nfortunately, minimal legislative history regarding the [PRPA] was recorded."[47] The Pennsylvania Superior Court, however, has stated that "[a] major concern of the legislature when it created the [PRPA] was confidentiality."[48] Like other peer review statutes, the confidentiality protections of the PRPA were designed "to serve the legitimate purpose of maintaining high professional standards in the medical practice for the protection of patients and the general public."[49] As the Pennsylvania Superior Court has recognized:

> the need for confidentiality in the peer review process stems from the need for comprehensive, honest, and sometimes critical evaluations of medical providers by their peers in the profession. Without the protection afforded through the confidentiality of the proceedings, the ability of the profession to police itself effectively would be severely compromised.[50]

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42. *Id.*

43. *See* 63 PA. STAT. AND CONS. STAT. ANN. § 425.1 (West 2017).

44. *Id.* § 425.3.

45. *Id.* § 425.4. The evidentiary privilege of the PRPA, found in section 425.4, is at the heart of *Reginelli* and is quoted and discussed in more detail below.

46. PRPA, Pub. L. 564, No. 193 (1974) (current version 63 PA. STAT. AND CONS. STAT. ANN. § 425.1).

47. Sanderson v. Frank S. Bryan, M.D., Ltd., 522 A.2d 1138, 1140 (Pa. Super. Ct. 1987).

48. *Id.* ("The purpose of the bill is to provide protection to those persons who give testimony to peer review organizations. Hearing on H.B. No. 1729, 158 Pa. Legis. J.-House at 4438 (1974) (statement of Representative Wells).").

49. Cooper v. Del. Valley Med. Ctr., 630 A.2d 1, 7 (Pa. Super. Ct. 1993), *aff'd*, 654 A.2d 547 (Pa. 1995).

50. Young v. W. Pa. Hosp., 722 A.2d 153, 156 (Pa. Super. Ct. 1998) (citation omitted).

The protections of the PRPA were never intended to be limitless. For example, the Pennsylvania Superior Court once stated that the PRPA "does not 'protect non-peer review business records, even if those records eventually are used by a peer review committee.'"[51] Additionally, the Pennsylvania Supreme Court established that the PRPA does not apply to a plaintiff-physician challenging peer review of his own work, where he alleged that the peer review was not done appropriately or in good faith.[52]

Prior to *Reginelli*, Pennsylvania state courts had, however, construed the PRPA rather broadly, aligned with the "overriding intent of the Legislature to protect peer review records."[53] The Pennsylvania Superior Court, for instance, held in 2005 that credentialing documents were protected under the PRPA, though the word "credentialing" appears nowhere in the statute.[54] In the same case, the Pennsylvania Superior Court refused to draw "a distinction between multi-person committees [explicitly mentioned in the PRPA] and single individuals [performing peer review functions]" under the PRPA.[55] The Pennsylvania Superior Court labeled the plaintiff's contrary as "flawed," stating that making such a distinction "would be a distracting and meaningless exercise" in light of the PRPA's goals.[56] Then, in 2006, the Pennsylvania Superior Court held that a peer review report generated by an outside specialist was protected, while also holding that a billing manager's presence within a peer review committee did not destroy the privilege.[57] Based on these holdings, prior to *Reginelli*, there existed a "pre-

51. Yocabet v. UPMC Presbyterian, 119 A.3d 1012, 1025 (Pa. Super. Ct. 2015) (quoting Dodson v. DeLeo, 872 A.2d 1237, 1242 (Pa. Super. Ct. 2005)).

52. Hayes v. Mercy Health Corp., 739 A.2d 114, 115 (Pa. 1999).

53. Troescher v. Grody, 869 A.2d 1014, 1022 (Pa. Super. Ct. 2005) (disapproved of by Reginelli v. Boggs, 181 A.3d 293, 305 n.9 (Pa. 2018)); *see also* Piroli v. Lodico, 909 A.2d 846, 849 (Pa. Super. Ct. 2006) (disapproved of by *Reginelli*, 181 A.3d at 305 n.9); *Young*, 722 A.2d at 156.

54. *Troescher*, 869 A.2d at 1022. Credentialing documents are documents created and reviewed in the course of deciding whether a physician is qualified to work in a hospital. *See generally Ambulatory Care Program: The Who, What, When, and Where's of Credentialing and Privileging*, JOINT COMMISSION, https://www.jointcommission.org/assets/1/6/AHC_who_what_when_and_where_credentialing_booklet.pdf (last visited Oct. 26, 2019).

55. *Troescher*, 869 A.2d at 1022.

56. *Id.*

57. *Piroli*, 909 A.2d at 851-52.

sumption that all peer review is generally protected from discovery."[58] After *Reginelli*, however, the existence of that presumption has become uncertain.[59]

IV. *REGINELLI V. BOGGS*

A. *Factual and Procedural History*

The evidentiary dispute in *Reginelli*, which implicated the PRPA, arose out of an action for medical malpractice.[60] Monongahela Valley Hospital (the hospital) contracted with UPMC Emergency Medicine, Inc. (the physician group) for emergency department physician staff and administrative services.[61] Doctors Marcellus Boggs and Brenda Walther were both employed by the physician group and served on the medical staff of the hospital.[62] This is a common arrangement in hospitals.[63] Dr. Walther was the director of the hospital's emergency department, and was Dr. Boggs's supervisor.[64]

Eleanor Reginelli was brought to the hospital's emergency department, where she was treated by Dr. Boggs for gastric discomfort.[65] A few days after her discharge, Mrs. Reginelli suffered a heart attack.[66] She and her husband alleged that Dr. Boggs had failed to diagnose her underlying condition.[67] The couple filed a complaint alleging negligence against Dr. Boggs, the hospital, and the physician group, corporate negligence against the hospital, and loss of consortium against all defendants.[68]

During her deposition, Dr. Walther testified that she maintained a performance file on Dr. Boggs, which included notes she created when reviewing a selection of Dr. Boggs' cases.[69] Dr. Walther maintained similar files for other emergency department physicians.[70] Learning of this, the Reginellis filed a discovery request, seeking to

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58. Mark A. Kadzielski & Jenna N. Scott, *Peer Review Privilege Limited by Pennsylvania Supreme Court Decision Has Implications for Healthcare Providers Nationwide*, BAKERHOSTETLER (Apr. 3, 2018), https://www.bakerlaw.com/alerts/peer-review-privilege-limited-by-pennsylvania-supreme-court-decision-has-implications-for-healthcare-providers-nationwide.

59. *Id.*

60. Reginelli v. Boggs, 181 A.3d 293, 296 (Pa. 2018).

61. *Id.*

62. *Id.*

63. *See Updated Physician Practice Acquisition Study*, *supra* note 32.

64. *Reginelli*, 181 A.3d at 296.

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.* at 297.

70. *Id.*

discover the performance file Dr. Walther maintained regarding Dr. Boggs.[71] After the hospital objected to the production of this file, citing the protection afforded under the PRPA, the Reginellis filed a motion to compel.[72] The trial court granted the motion, ordered the hospital to produce Dr. Boggs's performance file, included with its order a direction that the file remain confidential with the Reginellis' counsel, and ordered that the file not be copied or reproduced.[73] Though not previously involved with this action, the physician group filed a motion for a protective order, asserting its own protection under the PRPA for the peer review conducted by its employee, Dr. Walther.[74] Before the trial court ruled on the physician group's motion for protective order, both the physician group and the hospital appealed the trial court's order to the Pennsylvania Superior Court.[75]

The Pennsylvania Superior Court affirmed the trial court's order.[76] It held, first, that the physician group was not entitled to claim the protection of the evidentiary privilege under the PRPA because the physician group, "as an independent contractor, is not an entity enumerated in the [PRPA] as being protected by [the] peer review privilege."[77] Second, the superior court ruled that the hospital could not claim the privilege because it neither created nor maintained the performance file in question.[78] Third, the superior court stated that even if one of the parties could claim the privilege, the privilege had been destroyed when the physician group shared the performance file with the hospital.[79] The superior court thus rejected the physician group's contention that Dr. Walther was the only person to possess the file, stating "it is apparent that [the physician group] shared the file with [the hospital], since the Reginellis sought the file from [the hospital] and [the hospital] has provided it in camera."[80]

The hospital and physician group each appealed the decision to the Pennsylvania Supreme Court.[81] The Court granted review of the following issues with respect to the hospital:

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71. *Id.*
72. *Id.*
73. *Id.*
74. *Id.*
75. *Id.* at 298.
76. *Id.*
77. *Id.* at 299 (quoting Reginelli v. Boggs, Nos. 1584 WDA 2014 & 1585 WDA 2014, 2015 WL 6456401, at *3 (Pa. Super. Ct. 2015)).
78. *Id.* at 299 (citing *Reginelli*, 2015 WL 6456401, at *3).
79. *Id.* at 299.
80. *Id.* (quoting *Reginelli*, 2015 WL 6456401, at *3).
81. *Id.*

1. Whether the Superior Court erred by holding an outside medical provider's peer review proceedings regarding its employees who staff a hospital's Emergency Department under a contract with that hospital are not entitled to protection from disclosure under the [PRPA]?

2. Whether the sharing of peer review records by a third-party medical provider that operates a hospital's Emergency Department with the administration of that hospital constitutes a waiver of peer review protection as to those records?

3. Whether a hospital that contracts with a third-party medical provider to operate the hospital's Emergency Department may claim protection under the [PRPA] for records of peer review proceedings conducted by the medical provider regarding its employees who staff the hospital's Emergency Department?[82]

The Court also granted review of the following issues with respect to the physician group:

1. Whether the Superior Court's holding directly conflicts with previous Superior Court holdings that an outside entity can be appointed or retained by a hospital to conduct peer review and that the review is entitled to protection under the [PRPA]?

2. Whether the Superior Court's holding directly conflicts with the intent of the [PRPA] and this Court's holdings that the provision of peer review materials to the hospital does not constitute a waiver of the [PRPA]?[83]

B. Majority Opinion

Writing for a four-justice majority, Justice Christine Donohue first concluded that the language of the PRPA is "unambiguous," cautioning that the court could not ignore the language in pursuit of its spirit.[84] The court undertook a strict, narrow reading of the PRPA, reasoning that because the PRPA is an evidentiary exception, it should not be "expansively construed."[85] With this established, the court then examined the five questions on review in three main parts. First, it "consider[ed] [the physician group's] as-

82. *Id.* at 300 n.6.
83. *Id.*
84. *Id.* at 300 (citing 1 PA. STAT. AND CONS. STAT. ANN. § 1921(b) (West 2008)).
85. *Id.* (citing Commonwealth v. Stewart, 690 A.2d 195, 197 (Pa. 1997)).

sertion of its entitlement to claim the [PRPA's] evidentiary privilege" as a "professional health care provider" under the PRPA.[86] Second, the court considered the hospital's argument that it is a "professional health care provider" and that the PRPA's protection should apply to the performance review of one member of its medical staff, Dr. Boggs, by another member of its medical staff, Dr. Walther.[87] Third, it examined the arguments of the physician group and the hospital that the PRPA authorizes a hospital's peer review committee, like the one in operation at the hospital, to conduct peer review activities through an outside entity, like the physician group, pursuant to a contract.[88] Each of these main points is further explored below.

The relevant portion of the PRPA's evidentiary privilege is as follows:

> [t]he proceedings and records of a review committee shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action against a professional health care provider arising out of the matters which are the subject of evaluation and review by such committee and no person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such committee or as to any findings, recommendations, evaluations, opinions or other actions of such committee or any members thereof . . . .[89]

Noting that the PRPA's evidentiary privilege only applies to "professional health care providers" as defined in Section 425.2, the court rejected the physician group's argument that it was, indeed, a professional health care provider.[90] The court stated that—

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86. *Id.* at 302.
87. *Id.* at 304.
88. *Id.* at 306.
89. 63 PA. STAT. AND CONS. STAT. ANN. § 425.4 (West 2017).
90. *Reginelli*, 181 A.3d at 301-303 (quoting 63 PA. STAT. AND CONS. STAT. ANN. § 425.2) ("'Professional health care provider' means: (1) individuals or organizations who are approved, licensed or otherwise regulated to practice or operate in the health care field under the laws of the Commonwealth, including, but not limited to, the following individuals or organizations: (i) a physician; (ii) a dentist; (iii) a podiatrist; (iv) a chiropractor; (v) an optometrist; (vi) a psychologist; (vii) a pharmacist; (viii) a registered or practical nurse; (ix) a physical therapist; (x) an administrator of a hospital, nursing or convalescent home or other health care facility; or (xi) a corporation or other organization operating a hospital, nursing or convalescent home or other health care facility; or (2) individuals licensed to practice veterinary medicine under the laws of this Commonwealth.").

though the physician group is an organization made up of physicians (who, as individuals, are covered as professional health care providers under the PRPA)—the organization itself is "a business entity that provides hospitals . . . with staff involved with the provision of emergency medical services."[91] Moreover, the court held that the physician group, as an organization, is not an entity that is "approved, licensed or otherwise regulated to practice or operate in the health care field," stating that "[n]o principled reading of the definition of 'professional health care provider' permits any entity to qualify [for the privilege] if it is . . . . unregulated and unlicensed."[92] As such, the court affirmed the Pennsylvania Superior Court's ruling that the physician group was "not an entity enumerated in the [PRPA] as being protected by peer review privilege."[93]

The court next held that the hospital was not entitled to claim the evidentiary privilege under the PRPA through the actions of Dr. Walther.[94] Section 425.4 of the PRPA states that the "proceedings and records of a review committee . . . shall not be subject to discovery or introduction into evidence . . . ."[95] The hospital argued that this language allowed for the peer review proceedings and documents of an *individual*—Dr. Walther—to be privileged through the definition of "review organization" in Section 425.2,[96] arguing that the terms "review committee" and "review organization" are used interchangeably in the PRPA.[97] The court rejected this argument, determining that the two terms are not interchangeable "as they connote distinct types of entities under the PRPA."[98] The court found that the statute used the term "review committee" in the first sentence of its definition of "review organization" to apply specifically to committees "engaging in peer review[,]" while the second sentence of the definition includes a "'hospital board, committee or individual' involved in the review of the 'professional qualifications or activities of its medical staff" which the court deemed to be separate from peer review activities.[99]

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91. *Id.* at 303.
92. *Id.*
93. *Id.* at 304 (quoting Reginelli v. Boggs, Nos. 1584 WDA 2014 & 1585 WDA 2014, 2015 WL 6456401, at *3 (Pa. Super. Ct. 2015)).
94. *Id.* at 304.
95. 63 PA. STAT. AND CONS. STAT. ANN. § 425.4.
96. *Id.* § 425.2 ("[Review organization] shall also mean any hospital board, committee or individual reviewing the professional qualifications or activities of its medical staff or applicants for admission thereto.").
97. *Reginelli*, 181 A.3d at 304-05.
98. *Id.* at 305.
99. *Id.* (citing 63 PA. STAT. AND CONS. STAT. ANN. § 425.2).

The court conceded that it was possible Dr. Walther "may qualify as a 'review organization' under the second sentence of the PRPA's definition of that term, [but that] the PRPA does not extend its grant of the evidentiary privilege to *that* category of 'review organization'"[100] In emphasizing this point, the court specifically rejected the notion that the evidentiary privilege of the PRPA extends to "credentials review" (i.e., the review of a physician's clinical history to determine whether the physician is qualified for appointment to the medical staff), though the case did not present a credentialing question.[101] Thus, the court concluded that the hospital could not qualify for the peer review privilege through the review activities of Dr. Walther because neither the hospital nor Dr. Walther constituted a "'review committee' engaging in peer review."[102]

Finally, the court rejected the argument brought by the hospital and the physician group that "the lower courts erred in refusing to apply [the] PRPA's evidentiary privilege because a hospital's peer review committee may conduct protected peer review activities through an outside entity pursuant to a contract."[103] The two organizations argued that the lower courts failed to recognize that the hospital and physician group operated under a contract by which the physician group's employees could review clinical activity within the hospital.[104] The effect of this error, according to the organizations, was that the lower courts reviewed their activities individually, rather than collectively, making application of the PRPA's terms needlessly attenuated.[105] The court, however, determined that the organizations had failed to preserve the issue for appeal.[106] It stated that—even if the issue had been preserved—the organizations had failed to demonstrate the existence of a contract allowing the physician group to conduct peer review of activities performed within the hospital.[107] The court therefore concluded that the PRPA's peer review privilege did not apply to the physician group or the hospital, either individually or collectively, because the physician group waived the privilege when it shared the review files with the hospital.[108]

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100. *Id.* at 306 (emphasis added).
101. *See id.*
102. *Id.*
103. *Id.* at 306.
104. *Id.*
105. *See id.*
106. *Id.*
107. *Id.* at 307-08.
108. *Id.* at 308 n.16.

C. Dissenting Opinion

The three-justice dissent, written by Justice Wecht, rejected the court's threshold conclusion that the PRPA is clear and unambiguous, stating instead that it is "not a model of clarity."[109] The dissent observed that the court's interpretation of the PRPA contradicts the past conclusions of several members of the court, specifically regarding the term "professional health care provider."[110] The dissent pointed out that prior opinions (including the two three-justice opinions in *McClellan v. Health Maintenance Organization of Pennsylvania*) concluded that unenumerated organizations constituted professional health care providers if they were "in the same general class as administrators of health care facilities or organizations operating health care facilities."[111] The dissent also noted the Pennsylvania Superior Court's prior conclusions that the PRPA's definition of "review organization"[112] and its confidentiality provision (which contains the evidentiary privilege) were both ambiguous.[113] The dissent concluded that, "[t]he meaning of these terms being less than clear, the Court should turn to consider '[t]he occasion and necessity for the [PRPA],' '[t]he mischief to be remedied,' '[t]he object to be attained,' and '[t]he consequences of a particular interpretation.'"[114]

The dissent also asserted that the court erred in concluding that Dr. Walther did not conduct peer review.[115] The dissent stated that, contrary to the court's reasoning, the "bright line that the Majority seeks to draw between a review organization and a review committee," which supported its holding that the hospital could not claim the privilege through the actions of Dr. Walther, "cannot be sustained by the statutory text read holistically."[116] Though admitting that the court's reading had "some appeal" based on the separate uses of the terms "review organization" and "review committee," the dissent pointed out that Section 425.4, "entitled 'confidentiality of

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109. *Id.* at 308 (Wecht, J., dissenting).
110. *Id.* at 311 (citing McClellan v. Health Maint. Org. of Pa., 686 A.2d 801, 805 (Pa. 1996) (opinion in support of affirmance)).
111. *Id.* (citing *McClellan*, 686 A.2d at 808) (Nigro, J., opinion in support of reversal)).
112. *Id.* (citing Atkins v. Pottstown Mem'l Med. Ctr., 634 A.2d 258, 260 (Pa. Super. Ct. 1993)).
113. *Id.* (citing Sanderson v. Frank S. Bryan, M.D., Ltd., 522 A.2d 1138, 1140 (Pa. Super. Ct. 1987)).
114. *Id.* at 314 (citing 1 PA. STAT. AND CONS. STAT. ANN. § 1921 (West 2008)).
115. *Id.* at 313-14.
116. *Id.* at 314.

review *organization's* records,' refers in its text *only* to 'review committees,'" demonstrating that the PRPA itself uses the terms inconsistently, despite the court's reading.[117]

The dissent asserted that the court's holdings—finding that the evidentiary privilege applies to committees, not to individuals, and that *credentialing* review is not protected based on the PRPA's employment of the terms "review organization" and "review committee"—"leaves the door open to precisely the same chilling effect upon free and frank discussions aimed to ensure and improve an appropriate quality of care that the PRPA strives to vitiate."[118] Additionally, the dissent pointed out that the effect of the court's holding is that "no one supervisor can assess a given physician's performance negatively without risking exposure as the source of criticism, but if he or she does so with a colleague, and calls the twosome a 'committee,' precisely the same assessment is privileged."[119] This, the dissent reasoned, cannot have been the intent of the General Assembly, as it creates "a result that is absurd . . . or unreasonable," defying the principles of statutory construction.[120]

The dissent then turned to the court's conclusion that the physician group is not a professional health care provider.[121] The dissent agreed with the physician group's argument that it should be considered a health care provider under the PRPA because it is comprised of physicians, who are licensed and regulated under the PRPA's terms.[122] Moreover, the dissent noted the physician group, through its physicians, "operates an entire hospital department, with all the hiring, oversight, and administration that this entails," calling into question the court's "apparent conclusion that [the physician group] is not a 'corporation . . . operating a . . . health care facility.'"[123] That department—the emergency department at the hospital—is "subject to myriad regulations, and [the hospital] operates only with the approval of the Commonwealth and its agencies."[124] According to the dissent, drawing a distinction between the hospital department, the physicians that operate the department, and the organization to which those physicians ultimately belong, again undermines the ultimate purpose of the PRPA.[125] The dissent

117. *Id.*
118. *Id.* at 315.
119. *Id.*
120. *Id.* (citing 1 PA. STAT. AND CONS. STAT. ANN. § 1922(1) (West 2008)).
121. *Id.* at 315-16.
122. *Id.* at 318, 320.
123. *Id.* at 319-20.
124. *Id.* at 320.
125. *Id.*

also noted that arrangements like that between the physician group and the hospital are "commonplace,"[126] recognizing the parties' arguments that the court's holding ignored "the reality of modern health care, where outside physician practice groups *routinely* staff and are integral to the operation of hospitals."[127] Thus, the dissent would have concluded that the physician group "is an operator of a health care facility by virtue of having taken sole responsibility for operating the Department," stating that the court's "contrary interpretation guts the privilege" of the PRPA.[128]

The dissent further stated that it would have held that the sharing of the performance file between the physician group and the hospital did not waive the evidentiary privilege of the PRPA.[129] Rejecting the holding of the Pennsylvania Superior Court and the court's agreement with that holding, the dissent noted that the hospital "generally has maintained that Dr. Walther's peer review activities were conducted on behalf of both [the physician group] and [the hospital]," given the undeniable entwinement of the two organizations.[130] Thus, according to the dissent, the file remained exclusive to the two organizations for which it was created and maintained, pursuant to the PRPA's requirements.[131]

Finally, the dissent rejected the notion that "exclusivity" required that a *single, discrete* entity maintain control of a file at all times for it to be protected.[132] Instead, the dissent reasoned that the proper reading of "review organization" encompasses various enumerated entities and committees, stating that the language "clearly anticipates possession of such records by an array of individuals and groups concerned with evaluating and improving the quality of health care, reducing adverse events, and controlling costs."[133] Thus, the dissent concluded that the PRPA "was intended to capture an entire sector of conduct performed by a swath of individuals, committees, and government bodies on behalf of providers, both human and institutional."[134] The dissent stated that, because hospitals, physicians, and physician groups share a "collective responsi-

126. *Id.*
127. *Id.* at 318 (emphasis added) (quoting Brief for Appellant at 26, *Reginelli*, 181 A.3d 293 (Nos. 20 WAP 2016, 22 WAP 2016, 21 WAP 2016, 23 WAP 2016)).
128. *Id.* at 320.
129. *Id.*
130. *Id.* at 321-22.
131. *Id.* at 321.
132. *Id.* at 322.
133. *Id.*
134. *Id.*

bil[ity] for ensuring that the care delivered in the [emergency department] . . . satisf[ies] the standard of care," the PRPA should not be read to waive the evidentiary privilege when those entities share information necessary to carry out that responsibility.[135]

V. ANALYSIS AND IMPACT OF *REGINELLI*

The court in *Reginelli* made three key errors in examining whether the evidentiary privilege of the PRPA applied to the peer review file created by Dr. Walther in assessing Dr. Boggs. First, the court's conclusion that the PRPA is "unambiguous" immediately and mistakenly restricted its ability to apply the text of the PRPA to situations unforeseen by the General Assembly.[136] Second, the court demonstrated a fundamental misunderstanding of the operation of a modern hospital, leading it to make a sweeping decision out of step with the contemporary practice of medicine.[137] Finally, the court afforded little weight to the legislative intent of the General Assembly, instead conducting only a plain-text reading and application that produced unreasonable results.[138] Together, these errors shaped a decision that not only weakens the protection of the PRPA, but also weakens the security upon which physicians have been able to conduct thorough, candid reviews of their peers.[139] In the wake of *Reginelli*, physicians and other individuals who participate in the peer review process can no longer rely on the belief that their good-faith actions will remain confidential and privileged.[140] This countermands the important objectives of any peer review statute, and makes it less likely that physicians, going forward, will conduct the kind of effective peer review the PRPA was meant to encourage.

One of the overarching problems with the court's decision, as the dissent pointed out, is that it labeled the PRPA "unambiguous,"[141] per the Commonwealth's laws on statutory construction,[142] and used this purported lack of ambiguity to hold that the peer review protection is limited to a narrow set of circumstances.[143] Under the

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135. *Id.* at 323.
136. *Id.* at 300 (majority opinion).
137. *See id.* at 318-319 (Wecht, J., dissenting).
138. *Id.* at 300 (majority opinion).
139. *See* Elizabeth L. Melamed, *How Much Protection Does the Peer Review Protection Act Really Provide?*, BARLEY SNYDER (Apr. 9, 2018), https://www.barley.com/how-much-protection-does-the-peer-review-protection-act-really-provide.
140. *See id.*
141. *Reginelli*, 181 A.3d at 311.
142. *See* 1 PA. STAT. AND CONS. STAT. ANN. § 1921(b) (West 2008).
143. *Reginelli*, 181 A.3d at 308.

court's construction, it appears the PRPA will only apply to peer review that is conducted by a singular, pre-established peer review *committee*, organized under the hospital, rather than a physician group, investigating a specific instance of medical care.[144] This interpretation places the PRPA's now extremely limited protection well outside the norm of similar statutes across the nation,[145] and undermines the very purpose for which the PRPA was enacted by the General Assembly.[146]

While the majority opinion was correct in reviewing this case as presenting a matter of statutory construction, its threshold determination that the PRPA is "unambiguous" forced the court into a narrow reading that wholly disregards the purpose for which the statute was enacted.[147] Unlike the majority, which offered no explanation for its "unambiguous" determination, the dissent provided a compelling argument that the language of the PRPA is not, in fact, unambiguous.[148] The dissent pointed out that the PRPA has created confusion in the past, even within the Pennsylvania Supreme Court, noting that members of the court had previously deemed the terms of the PRPA to be broad and open to interpretation.[149] A recognition of the PRPA's ambiguity would have allowed the court to consider, among other principles of statutory construction, "[t]he occasion and necessity for the statute[,]" "[t]he circumstances under which it was enacted[,]" "[t]he object to be attained

144. *Id.* at 304-06.

145. *See, e.g.*, Armstrong v. Dwyer, 155 F.3d 211, 220 (3d Cir. 1998) (noting that the peer review protection afforded by 42 U.S.C. §§ 1390c-9(d), 1320c-3 (2012), "run[] with the documents or information, not with the organization or individuals who happen to possess the documents or information"); Vranos v. Franklin Med. Ctr., 862 N.E.2d 11, 19 (Mass. 2007) (holding that credentialing records shared between multiple in-state and out-of-state entities were covered by the Massachusetts peer review privilege, given the legislature's intent to provide broad protection for thorough, candid review of physician performance); Day v. Finley Hosp., 769 N.W.2d 898, 902 (Iowa Ct. App. 2009) (holding that the Iowa peer review statute applied to all "investigation files," "reports," and "other investigative information" relating to a given case in the possession of the peer review committee, regardless of whether the information was generated by the committee).

146. *See Reginelli*, 181 A.3d at 320 (Wecht, J. dissenting) ("This Court should not adopt an unreasonable or impractical interpretation that so clearly frustrates legislative intent.").

147. *See id.*

148. *Id.* at 311.

149. *Id.* (quoting McClellan v. Health Maint. Org. of Pa., 686 A.2d 801, 805 (Pa. 1996) (opinion in support of affirmance) ("[The PRPA's] definition of 'professional health care provider' . . . [is] broad enough that we may or may not read the Act as explicitly excluding [organizations such as health maintenance organizations]. The words of the Act defining 'health care provider,' then, are ambiguous."); *see also McClellan*, 686 A.2d at 808 (Nigro, J., opinion in support of reversal)) ("[W]hether [health maintenance organizations] are in the same general class as administrators of health care facilities or organizations operating health care facilities is subject to interpretation.").

[by the statute,]" and "other statutes upon the same or similar subjects."[150] By failing to recognize the lack of clarity in the terms of the PRPA, the court erroneously bound itself to a narrow reading of those terms, which led to an interpretation inconsistent with the reality of the peer review process.[151]

The court's holding that the physician group is not a "professional health care provider" that can claim the protection of the peer review privilege stems directly from its determination that the PRPA's language is "unambiguous," and, as a result, does not hold up to practical scrutiny.[152] The court's primary reason for dismissing the physician group's contention that it is a "professional health care provider" was that, as an entity, it is not licensed and regulated in the delivery of medical care.[153] But the physician group is an organization made up of physicians, who *are* licensed and regulated in the delivery of medical care.[154] Dr. Walther's employment within a physician group should not obviate her ability to claim the protection afforded under the PRPA. Along with creating an arbitrary legal divide between physicians employed by physician groups and those employed by a hospital, this ruling undermines the purpose of the PRPA as it exists today, when most physicians *do* belong to a physician group.[155]

The court wrote off part of this argument in a footnote, stating that entities like the physician group existed when the PRPA was enacted, but the court failed to consider their increased prevalence now.[156] In fact, modern hospitals rely on these types of organizations for a large percentage of their medical staff.[157] While hospitals are beginning to employ more physicians themselves, independent physicians still make up a significant portion of the average hospital medical staff.[158] And many employed physicians (i.e., non-independent physicians) are employed by physician groups, which contract with hospitals.[159]

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150. 1 PA. STAT. AND CONS. STAT. ANN. § 1921(c) (West 2008).

151. *See Reginelli*, 181 A.3d at 300, 305 n.12 (majority opinion).

152. *Id.* at 303.

153. *Id.*

154. *See id.* at 296 (discussing the physician group as an entity that contracted with the hospital "to provide staffing and administrative services for its emergency room," including Dr. Walther and Dr. Boggs).

155. *See* Bita Kash & Debra Tan, *Physician Group Practice Trends: A Comprehensive Review*, J. HOSP. & MED. MGMT., Mar. 21, 2016, at 1, 1 ("Today, most physicians work in the group practice setting in the United States.").

156. *Reginelli*, 181 A.3d at 303 n.7.

157. *See* Travis Singleton & Phillip Miller, *The Physician Employment Trend: What You Need to Know*, FAM. PRAC. MGMT., July-Aug. 2015, at 11, 13.

158. *Id.*

159. Kash & Tan, *supra* note 155, at 1.

Apart from the practical impact of the court's determination that a physician group is not a health care provider, the dubiousness of the court's reasoning is made clear by its own summation of its ruling on this issue. The court stated that "while [the physician group] is an organization that is comprised of hundreds of 'professional health care providers' (namely, physicians), it is not itself a 'professional health care provider' because it is unregulated and unlicensed."[160] To support its reasoning, the court cited *Yocabet v. UPMC Presbyterian*, in which the Pennsylvania Superior Court held that the Pennsylvania Department of Health did not qualify as a "professional health care provider" under the PRPA.[161] Baffllingly, though, the court borrowed language from *Yocabet*, in which the Pennsylvania Superior Court stated that the Department of Health "is a fictitious entity that can only operate through its agents and employees."[162]

The court went no further in explaining its use of this quote, which appears to undercut its holding. After all, if a "fictitious entity" is made up of individuals who are licensed and regulated in accordance with the PRPA, and it is those individuals' actions that the PRPA is designed to protect against publicity, why should that protection not extend to the entity named in the suit on behalf of the individual? The court provided no answer to this question. However, as the dissent pointed out, the opinion in support of affirmance in *McClellan* addressed this argument, noting the court's "statutory construction doctrine[,] *ejusdem generis* ('of the same kind or class')."[163] The dissent stated that, according to the doctrine, the definitions in the PRPA should be read expansively, given the introductory language "including, but not limited to."[164]

The court's holding that the hospital could not claim the peer review privilege through the review actions of Dr. Walther is another direct result of its flawed conclusion that the language of the PRPA is unambiguous. Key to the court's reasoning is the PRPA's dual use of the terms "review organization" and "review committee."[165] The term "review organization" is defined within the text of the PRPA using broad language, which makes room for a wide spectrum of committees, including "committees" consisting of a single

160. *Reginelli*, 181 A.3d at 303.
161. *Id.* at 303-04 (citing Yocabet v. UPMC Presbyterian, 119 A.3d 1012, 1024 (Pa. Super. Ct. 2015)).
162. *Id.* at 304 (quoting *Yocabet*, 119 A.3d at 1022).
163. *Id.* at 317 (Wecht, J., dissenting) (quoting McClellan v. Health Maint. Org. of Pa., 686 A.2d 801, 805 (Pa. 1996)).
164. *Id.* at 317 (citing 63 PA. STAT. AND CONS. STAT. ANN. § 425.2 (West 2017)).
165. *Id.* at 304-05 (majority opinion) (citing 63 PA. STAT. AND CONS. STAT. ANN. § 425.2).

individual.[166] The term "review committee" is not defined in the PRPA,[167] though the court stated that it is.[168] Specifically, the court wrote, "[t]he first sentence of the definition of 'review organization' defines the type of entity that constitutes a 'review committee,' namely, 'any committee engaging in peer review.'"[169] Despite the court's insistence that its interpretation is based on a plain-text reading of the PRPA,[170] a reading of the definition of "review organization" indicates otherwise.[171] The PRPA *defines* "review organization" as follows:

> "[r]eview organization" means any committee engaging in peer review, including a hospital utilization review committee, a hospital tissue committee, a health insurance review committee, a hospital plan corporation review committee, a professional health service plan review committee, a dental review committee, a physicians' advisory committee, a veterinary review committee, a nursing advisory committee, any committee established pursuant to the medical assistance program, and any committee established by one or more State or local professional societies, to gather and review information relating to the care and treatment of patients for the purposes of (i) evaluating and improving the quality of health care rendered; (ii) reducing morbidity or mortality; or (iii) establishing and enforcing guidelines designed to keep within reasonable bounds the cost of health care. It shall also mean any hospital board, committee or individual reviewing the professional qualifications or activities of its medical staff or applicants for admission thereto. It shall also mean a committee of an association of professional health care providers reviewing the operation of hospitals, nursing homes, convalescent homes or other health care facilities.[172]

The court failed to acknowledge that the first sentence of this definition contains a non-exhaustive list of "committee[s] engaging in peer review," many of which are not labeled as "review committees."[173] Instead of seeing the definition as broadly applicable to a

166. 63 PA. STAT. AND CONS. STAT. ANN. § 425.2(2).
167. *Id.* § 425.2.
168. *See id.*; *see also Reginelli*, 181 A.3d at 305.
169. *Reginelli*, 181 A.3d at 305 (citing 63 PA. STAT. AND CONS. STAT. ANN. § 425.2).
170. *Id.* at 300.
171. *See* 63 PA. STAT AND CONS. STAT. ANN. § 425.2(2).
172. *Id.*
173. *Reginelli*, 181 A.3d at 305 (citing 63 PA. STAT. AND CONS. STAT. ANN. § 425.2(2)).

wide variety of review activities with the same protectable qualities, the court appears to have contorted the language to fit its reasoning. Additionally, the court's conclusion that the first and second sentences of this definition refer to entirely different review processes appears to ignore the plain language of those sentences.[174] While the first sentence, indeed, applies specifically to various types of review committees, as the court noted, the second sentence includes individuals in a hospital who "review[] the professional qualifications *or activities of its medical staff.*"[175] Given the interest of the PRPA in protecting the anonymity of reviewing physicians, this broad "activities" language surely includes clinical activities as would fall within the purview of a peer reviewer.[176] This is especially true when considering that peer review, itself, occurs both when "credentialing" an applicant for admission to a hospital's medical staff (ensuring that the applicant meets the relevant qualifications), and when reviewing the performance of a physician already on the medical staff,[177] like the review Dr. Walther conducted regarding Dr. Boggs' performance.[178]

As discussed above, there is scant evidence of the General Assembly's intent in enacting the PRPA beyond the historical and statutory note describing the PRPA before its passage and the legislative history of similar laws in other states.[179] Because of these limitations, it is understandable that the court may have been reluctant to rely solely on the few examples of the General Assembly's intent. But even in considering the limited evidence of legislative intent, as the court did,[180] along with the text of the statute, it is difficult to wrap one's head around the notion that a file such as the one Dr. Walther maintained for Dr. Boggs would *not* be considered the product of peer review. After all, Dr. Walther created and maintained this file as part of her regular review of the performance of a physician she supervised, with the objective of improving the quality of care.[181]

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174. *Id.* at 305-06.

175. *Id.* (emphasis added).

176. *See* Robinson v. Magovern, 83 F.R.D. 79, 86 (W.D. Pa. 1979) (discussing the legislature's intent to "foster the greatest candor and frank discussion at medical review committee meetings" and "encourage peer evaluation of health care provided" through the PRPA's evidentiary privilege).

177. Nijm, *supra* note 14, at 543.

178. *Reginelli*, 181 A.3d at 297.

179. PRPA, Pub. L. 564, No. 193 (1974) (current version 63 PA. STAT. AND CONS. STAT. ANN. § 425.1 (West 2017) ("An Act providing for the increased use of peer review groups by giving protection to individuals and data who report to any review group").

180. *Reginelli*, 181 A.3d at 300.

181. *Id.* at 298 (citing Defendant's Motion for Reconsideration at ¶ 21, *Reginelli*, No. 1584 WDA 2014 (Pa. C.P. Washington County Aug. 29, 2014)).

Generally speaking, this is the type of file that is designed to be kept confidential by the peer review privilege, given the goals of peer review protection statutes.[182] Thus, upholding the peer review protection in this case would not have required the court to ignore the language of the PRPA in pursuit of its spirit, as the court warned of, but instead would have required the court to read and interpret the PRPA in light of its *purpose*.[183] The dissent highlighted this point numerous times, but it is worth underscoring.[184] In failing to properly account for the intent of the General Assembly, the court "negate[d] the presumption that all peer review is generally protected from discovery."[185]

As stated, the court's decision, which severely limits the application of the PRPA's evidentiary privilege, threatens the important aims of the PRPA. By disturbing physicians' ability to rely on the PRPA's evidentiary privilege, the court has created serious doubts as to whether physicians will be able to conduct effective peer review.[186] Without the guarantees of "confidentiality [that are] critical to such review," there is a real possibility that the PRPA's goals of ensuring patient safety and upholding high standards of care will be compromised.[187]

VI. PROPOSED LEGISLATIVE RESPONSE

Given the PRPA's important objectives, the Pennsylvania General Assembly must now act quickly to amend it, clarifying that the evidentiary privilege is meant to apply to the broad range of peer review activities occurring in modern hospitals. As has been observed, prior to *Reginelli*, files and processes like those at issue in the case "were previously thought to be protected from discovery by

182. Kohlberg, *supra* note 1, at 161 ("[T]he purpose of peer review statutes is to protect the confidentiality of an ongoing peer review process, not simply to protect records produced by formally defined peer review committees.") (citation omitted).

183. *Reginelli*, 181 A.3d at 300 (citing 1 PA. STAT. AND CONS. STAT. ANN. § 1921(b) (West 2008)).

184. *See id.* at 320 (Wecht, J., dissenting).

185. Kadzielski & Scott, *supra* note 58.

186. Shortly after *Reginelli* was rendered, the Hospital and Healthsystem Association of Pennsylvania (HAP), a hospital advocacy group, sent a memorandum to its member hospitals stating that, in its view, the case "casts substantial doubt about the availability of peer review privilege protection for a range of activities." Memorandum from Andy Carter, President and CEO of HAP, to CEOs of HAP Member Hosps. (May 4, 2018), https://www.haponline.org/Portals/0/docs/HAP-Memo-18-10-Reginelli-v-Boggs.pdf?ver=2018-05-10-123633-790. These activities include "[p]eer review conducted by contracted providers for hospital-based services . . . non-licensed entities that employ physicians . . . [and] health care facilities that do not require state licensure" along with "[c]redentialing review in any setting." *Id.*

187. *See* Kadzielski & Scott, *supra* note 58.

the [PRPA]."[188] In the wake of *Reginelli*, that valuable presumption has been replaced with another: that only a review conducted by a pre-established "peer review committee" of more than one person, on behalf of the hospital, will be protected by the PRPA's evidentiary privilege.[189] Therefore, for example, peers within a physician group reviewing their colleagues' activities to improve clinical performance may not be protected.[190] Nor—as the *Reginelli* dissent pointed out—may supervisors reviewing the cases of their supervisees.[191] Assuming the General Assembly did not mean to prescribe such a narrow process of protectable peer review, it should now work with physician groups and hospital associations to amend the PRPA to reflect the staffing and operations of modern hospitals.

At a minimum, the General Assembly should unify the use of the terms "review committee" and "review organization" within the PRPA. Because a great deal of the court's analysis in *Reginelli* rested on the inconsistent use of these terms, the General Assembly should consider replacing the nine references to a "review committee" in section 425.4[192] with the term "review organization," as defined in section 425.2.[193] If this language had been consistent throughout both sections when the court heard *Reginelli*, and Dr. Walther were considered a "review organization," as the court conceded she may have been, the review of Dr. Boggs would likely have been protected under section 425.4.[194] By unifying these terms in light of *Reginelli*, the General Assembly can confirm its intent to protect the type of review conducted by Dr. Walther.

But given the important goals of the peer review process and the need for greater clarity in an increasingly complex health care environment, the General Assembly might consider adopting a peer review statute like Oklahoma's, which grants broad, unambiguous protection for a wide range of "health care entities" for both credentialing and peer review.[195] Under the Oklahoma statute, "peer re-

188. Melamed, *supra* note 139.

189. *Reginelli*, 181 A.3d at 304-06 (majority opinion) (holding that Dr. Walther's review of Dr. Boggs' performance could not be protected under the PRPA, either as fellow employees of the physician group or through their work at the hospital).

190. *See id.*

191. *Id.* at 315 (Wecht, J., dissenting).

192. 63 PA. STAT. AND CONS. STAT. ANN. § 425.4 (West 2017).

193. *Id.* § 425.2(2).

194. *Reginelli*, 181 A.3d at 306 (majority opinion) (emphasis added) (stating that while Dr. Walther "may qualify as a 'review organization'" under section 425.2(2), the PRPA "does not extend its grant of the evidentiary privilege to *that* category of 'review organization'" in section 425.4, which refers instead to a "review committee").

195. OKL. ST. ANN. tit. 63, § 1-1709.1 (West, Westlaw through Second Regular Sess. of the 56th Legis.); *see also* Michael E. Joseph, *Oklahoma Legislature Significantly Expands Peer*

view process" is defined as "any process, program or proceeding, including a credentialing or recredentialing process, utilized by a health care entity or county medical society to assess, review, study or evaluate the credentials, competence, professional conduct or health care services of a health care professional."[196] The Oklahoma statute also presents a reasonable balance between the objectives of a confidential peer review process and the interests of potential plaintiffs, specifically exempting medical records, incident reports, and other factual information regarding patient treatment.[197]

In amending the PRPA, the Pennsylvania General Assembly should consider the two major interests at stake in potential health care litigation: protecting the sanctity of the peer review process while preserving the legitimate interests of patient-plaintiffs. Specifically, the General Assembly should protect a wide range of good-faith peer review activities aimed at improving quality of care—including those activities conducted by individuals and non-hospital organizations—while exempting the categories of records patient-plaintiffs require to bring lawsuits, such as the incident reports exempted in Oklahoma's peer review statute.[198] Documents stemming from reviews like Dr. Walther's—a regular review of the clinical work of a colleague—should be protected because they are created with the goal of improving patient care.[199] On the other hand, reviews conducted for other purposes, like reviews by health insurers or other outside entities conducted purely for business purposes,[200] should not be protected from discovery because they do not require the guarantees of confidentiality that the peer review privilege affords. Ultimately, the General Assembly must consider the interests of hospital and physician associations and patient advocacy groups to strike the necessary balance. By doing so, the General Assembly can remedy the damage and confusion regarding the PRPA caused by the court in *Reginelli*, while creating a clearer, stronger peer review protection.

Review Privilege, MCAFEE & TAFT (Dec. 1, 2014), https://www.mcafeetaft.com/oklahoma-legislature-significantly-expandspeerreviewprivilege ("[A] health care entity may utilize a process, program, or proceeding established, maintained, provided, or operated by another body or entity, including those located outside the state.").

196. tit. 63, § 1-1709.1(6).

197. *See id.* § 1-1709.1(5).

198. *Id.* § 1-1709.1(A)(5)(b).

199. *See Reginelli*, 181 A.3d at 296-97.

200. *See* Venosh v. Henzes, M.D., 121 A.3d 1016, 1019 (Pa. Super. Ct. 2015) (holding that the PRPA does not protect documents generated by a health insurer reviewing the work of health care providers to determine whether it "should continue to contract with the health care providers in question."). In *Venosh*, the Pennsylvania Superior Court specifically stated that protecting documents stemming from this type of review would not fulfill the "intent behind the [PRPA]." *Id.*

VII. CONCLUSION

Peer review is a vital tool for hospitals and physician groups to ensure that patients receive safe, competent care.[201] As such, it is imperative that the evidentiary privilege of the PRPA be clear and reliable, and for hospitals, physician groups, and others who participate in the peer review process to understand how and when its protections will apply. With its questionable holding in *Reginelli,* the Pennsylvania Supreme Court created confusion and instability around the PRPA, calling into question when, precisely, the evidentiary privilege will protect the records of physicians and committees engaging in peer review.[202] In light of this ruling, there is a significant risk that peer review conducted across the Commonwealth of Pennsylvania will be inadequate, based on a fear that the records generated will *not* be confidential and privileged. This has the serious potential to jeopardize patient safety. The Pennsylvania General Assembly must now act quickly to remedy the detrimental effects of this decision, making clear that the PRPA is meant to protect a broad scope of peer review processes performed by a range of individuals and entities engaged in patient care. Doing so has the potential to save lives.

201. Kohlberg, *supra* note 1, at 157.
202. Melamed, *supra* note 139.